



Bureau of Local Health & Administrative Services
Division of Health, Wellness and Disease Control
Sexually Transmitted Disease (STD) Section

Guidance for Health Care Providers

Expedited Partner Therapy (EPT) For Chlamydia and Gonorrhea

Public Act 525 of 2014 (MCL 333.5110) authorized the use of expedited partner therapy (EPT) for certain sexually transmitted diseases as designated by the state health department. In January 2015, the department designated chlamydia and gonorrhea as diseases for which the use of EPT is appropriate. This document provides health care providers with guidance for using EPT.

Expedited Partner Therapy (EPT): Another Tool for STD Prevention and Control

Sexually transmitted diseases (STDs) are a significant public health problem. In Michigan, reported cases of gonorrhea and chlamydia exceed 55,000 annually; making them the two most commonly reported infections. They are highly contagious as well as easy to treat. Rates of chlamydia are highest in men and women under the age of 24, increasing the potential for negative outcomes related to fertility resulting from untreated infection.

To prevent further transmission of these STDs, clinicians now have another option to assure that individuals who are at risk due to exposure are provided treatment. A recent amendment to the Public Health Code¹ authorized the use of Expedited Partner Therapy (EPT), which enables clinicians to provide patients with medication or a prescription to deliver to their sex partner(s) without a medical evaluation or clinical assessment of those partners. Furthermore, health professionals who provide EPT in accordance with the law are not subject to liability, except in the case of gross negligence.

EPT is an alternative strategy to assure that sexual partners of patients diagnosed with uncomplicated *Chlamydia trachomatis* (CT) or *Neisseria gonorrhoeae* (GC) are treated. Due to the high risk of repeat infection from exposure to untreated partners, patients diagnosed with CT or GC cannot be considered adequately treated until all of their partners have been treated. This is particularly important given the asymptomatic nature of these infections. Traditional methods to notify and treat sex partners (i.e., health department assisted referral and patient referral) are the cornerstone of STD control and should be considered the gold standard; however, it is imperative that partner management options be examined for each patient. EPT is a useful alternative when a partner is unable or unlikely to seek care. It is a proven effective intervention that is highly recommended by the Centers for Disease Control and Prevention (CDC).²

Selecting Appropriate Patients for EPT

EPT can be considered for the partners of patients with a clinical or laboratory diagnosis of chlamydia or gonorrhea infection. Laboratory confirmation of the diagnosis may be based on the findings of culture, microscopy, or a FDA-approved molecular test. Providing EPT without laboratory confirmation may be considered

¹ Public Act 525 of 2014 (MCL 333.5110) effective January 14, 2015.

² Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. MMWR 2015; 64 (No. 3): pp. 8-9.

when the provider has a high clinical suspicion of infection and there is concern the patient will be lost to follow-up.

Clinicians should attempt to refer partners in for comprehensive healthcare including evaluation, testing, and treatment. Clinical services provide the opportunity to confirm the exposure and/or diagnosis, examine the patient, test for other STDs including HIV, ensure treatment, and offer additional services such as family planning, vaccinations, and risk-reduction counseling.

Patients most appropriate for EPT are those with partners who are unable or unlikely to seek prompt clinical service. Factors to consider include whether the partner is uninsured, lacks a primary care provider, faces significant barriers to accessing clinical services, or is unwilling to seek care. The acceptability of EPT to the patient and partners should also be assessed. EPT does not preclude attempts to get partners into care. Even if EPT is provided, the partner should be encouraged to seek follow-up care as soon as possible.

The partners of infected clients within the 60 days prior to treatment are the best candidates for EPT as they are at highest risk for infection. If the last sexual encounter was more than 60 days prior, the most recent sexual partner should be treated. There is no limit on how many partners can be provided treatment via EPT. A combination of partner strategies can also be used. For example, a patient with several partners may refer one or more partners to the clinic and take EPT for other partners. If a partner is pregnant, every effort should be made to contact her for a referral to pregnancy services and/or pre-natal care.

EPT should **not** be used for the following:

- In cases of suspected child abuse or sexual assault.
- In situations where a patient's safety is in question.
- For partners with known allergies to antibiotics.
- For patients who are co-infected with STDs other than chlamydia or gonorrhea.
- For treating gonorrhea among men who have sex with men, due to the lack of data to demonstrate the effectiveness in this population and the risk of missing STD/HIV co-infections.

Recommended Drug Regimens for EPT

Currently, the only recommended drug regimens for treatment of chlamydia and gonorrhea using EPT are:

- For sexual partners of patients with chlamydia, but not gonorrhea: Azithromycin (Zithromax) 1 gram orally in a single dose.³
- For sexual partners of patients with gonorrhea, regardless of the chlamydia test result: Cefixime (Suprax) 400 mg orally in a single dose, **plus** Azithromycin (Zithromax) 1 gram orally in a single dose.⁴

The medication for EPT may be dispensed or prescribed. The preferred method is dispensing in a unit-use dose as part of a partner packet that includes medication, informational materials, and a clinic referral. If dispensing is not an option, prescriptions can be provided in the partner packet instead of medication. If a prescription is provided:

- Individual prescriptions are given for each partner
- The prescription should be made out in the partner's name, if possible
- If the partner's name is unknown, the prescription is made out to "Expedited Partner Therapy"
- In this instance, use January 1 of the current year as the date-of-birth.

Risk of Under-Treating Complicated Infections, Pharyngeal Gonorrhea, and Missing Concurrent STD/HIV Infection

Oral cephalosporins are less effective in eradicating pharyngeal gonorrhea infection, so inadequate treatment of partners with pharyngeal infection is a potential limitation of EPT. Providers should ascertain the risk by discussing oral sex with their patient and not offer EPT to partners at risk for pharyngeal infection. These partners should seek clinical services where ceftriaxone treatment is available. Another concern when using EPT is missing concurrent STD and HIV infections. This risk can be mitigated through educational materials that clearly instruct EPT recipients to see a health provider for STD and HIV testing.

³ Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. MMWR 2015; 64 (No. 3): pp. 56-57.

⁴ Ibid. pp.62-64.

EPT and Pregnancy

Although EPT is not contraindicated when a patient reports that a female partner may be pregnant, providers should assess whether the pregnant partner is receiving pregnancy services or prenatal care. Every effort should be made to contact the pregnant partner and ensure appropriate care; EPT should be considered as a last resort. The local health department may be of assistance for these special situations. All recommended EPT treatment regimens are considered safe in pregnancy; however, doxycycline, a potential alternative to azithromycin for treating chlamydia, should not be used during pregnancy.

Patient Counseling Messages for EPT

- Partners should seek a complete STD evaluation as soon as possible, regardless of whether they take the medication.
- Partners should read the informational material very carefully before taking the medication.
- Partners who have allergies to the antibiotics or who have serious health problems should not take the medications and should see a healthcare provider.
- Partners who have symptoms of a more serious infection (e.g. pelvic pain in women, testicular pain in men, and fever in women or men) should not take the EPT medication and should seek care as soon as possible.
- Partners who are or could be pregnant should seek care for their pregnancy as soon as possible.
- Patients and partners should abstain from sex for at least seven days after treatment and until seven days after all partners have been treated, in order to decrease the risk of repeat infection.
- Partners should be advised to seek clinical services for retesting three months after treatment.

Patient Follow-Up and Retesting at Three Months

High prevalence of chlamydia and gonorrhea infection has been observed in women and men after treatment; therefore, the CDC recommends that these patients be retested 3 months after treatment, regardless of whether they believe their sex partners were treated. Partners should also be encouraged to get tested 3 months after treatment.

Frequently Asked Questions

Q1: What if the partner has an adverse reaction to the medication?

EPT has been used across the country since 2005. The medications are highly effective, single-dose antibiotics. Adverse reactions are rare; the most common known reaction is mild gastrointestinal intolerance. California, the first state to use EPT, established a dedicated hotline to monitor adverse reactions. After nearly 10 years with no reports, the hotline was discontinued.

Q2: Won't EPT compromise the quality of care provided to partners?

When used selectively, EPT will actually benefit partners who would not otherwise receive treatment. Furthermore, these risks can be mitigated through patient education and written materials for partners that provide warnings and encourage them to visit a healthcare provider.

Q3: Will the use of EPT contribute to the development of population-level antibiotic resistance?

There is no evidence that EPT leads to drug-resistance. Even if EPT was used on all three million chlamydia cases reported annually, it would only increase the overall use of azithromycin by less than five percent. Gonorrhea has developed resistance to several antibiotics; however, there is no evidence that the use of EPT increases the likelihood this will occur. It is important that when EPT is used for a client diagnosed with gonorrhea, re-testing should be strongly emphasized. For persistent infections, use culture testing to rule out resistance.

For more information about EPT or other issues pertaining to STD, please contact the Michigan Department of Health and Human Services STD Program at (517) 241-0870 or www.michigan.gov/hivstd.

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